TABLE OF CONTENTS

Pathologic Diagnosis/Initial Evaluation.................................................................Page 2
Classic Hodgkin Lymphoma Stage I-II................................................................. Pages 3-4
Classic Hodgkin Lymphoma Advanced Stages III, IV.........................................Pages 5-6
Lymphocyte Predominant Hodgkin Lymphoma....................................................Page 7
Follow-up After Completion of Treatment..........................................................Page 8
Salvage Therapy....................................................................................................Page 9
APPENDIX A: Unfavorable Risk Factors for Stage I-II Classic Hodgkin Lymphoma. Page 10
APPENDIX B: Deauville Criteria/5-Point Scale (5PS).............................................Page 10
APPENDIX C: Radiation Therapy Guidelines.......................................................Page 11
APPENDIX D: International Prognostic Score (Hasenclever Index)......................Page 12
APPENDIX E: Systemic Therapy for Relapsed or Refractory Disease....................Page 13
Suggested Readings..............................................................................................Pages 14-16
Development Credits.......................................................................................... Page 17
Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

NOTE: Consider Clinical Trials as treatment options for eligible patients.

### INITIAL EVALUATION

#### ESSENTIAL:
- **History and physical including:**
  - Alcohol intolerance
  - Performance Status
  - Pruritus
  - Fatigue
  - Exam of nodes
  - Size of spleen, liver
  - B symptoms (unexplained fever > 38°C during the previous month; Recurrent drenching night sweats during the previous month; Weight loss > 10% of body weight ≤ 6 months of diagnosis)
- **CBC with differential, LDH, BUN, creatinine, albumin, AST, ALT, total bilirubin, alkaline phosphatase, serum calcium, uric acid**
- **Erythrocyte sedimentation rate (ESR)**
- **Screening for HIV 1, HIV 2, hepatitis B and C (HBcAb, HBsAg, HCVAb)**
- **PET/CT with contrast**
- **Pulmonary Function Tests**
- **Consider bone marrow biopsy if there are cytopenias and/or inconclusive PET**
- **MUGA scan or echocardiogram**
- **Counseling: psychosocial if clinically indicated**
- **Lifestyle risk assessment**
- **Discuss fertility options and sperm banking for patients of child bearing potential (refer to Fertility Preservation Prior to Cancer Treatment (Women) algorithm)**

#### OF USE IN CERTAIN CIRCUMSTANCES:
- **Immunohistochemical studies:**
  - LMP1
  - BOB1, OCT2, and CD79a (diagnostic distinction with B-cell lymphoma, unclassifiable with features intermediate between classic HL and DLBCL and primary mediastinal large B-cell lymphoma).
  - CD23, or CD35 (follicular dendritic cell markers), BCL6 in cases of nodular lymphocyte predominant HL (may help with T-cell/histiocyte rich large B-cell lymphoma)
  - CD2, CD43, ALK (diagnostic distinction with anaplastic large cell lymphoma)
- **STRONGLY RECOMMEND:**
  - Core biopsy for tissue banking by protocol

### ESSENTIAL:
- **FNA alone is insufficient**
- **Hematopathology review of all slides with at least one tumor paraffin block. Re-biopsy if consult material is non-diagnostic. Core needle biopsy may be adequate if diagnostic, but an excisional nodal biopsy is recommended.**
- **Flow cytometry often not helpful**
- **Adequate immunophenotype to confirm diagnosis**
  - Immunohistochemistry on paraffin panel for Hodgkin lymphoma (HL) including nodular lymphocyte predominant HL:
    - CD20, PAX-5, CD30, CD3, CD15, CD21, and CD45 (LCA)
    - EBER
- **Adequate immunophenotype to confirm diagnosis**
  - CD20, PAX-5, CD30, CD3, CD15, CD21, and CD45 (LCA)
  - EBER
- **Immunohistochemistry on paraffin panel for Hodgkin lymphoma (HL) including nodular lymphocyte predominant HL:**
  - CD20, PAX-5, CD30, CD3, CD15, CD21, and CD45 (LCA)
  - EBER

#### OF USE IN CERTAIN CIRCUMSTANCES:
- **Immunohistochemical studies:**
  - LMP1
  - BOB1, OCT2, and CD79a (diagnostic distinction with B-cell lymphoma, unclassifiable with features intermediate between classic HL and DLBCL and primary mediastinal large B-cell lymphoma).
  - CD23, or CD35 (follicular dendritic cell markers), BCL6 in cases of nodular lymphocyte predominant HL (may help with T-cell/histiocyte rich large B-cell lymphoma)
  - CD2, CD43, ALK (diagnostic distinction with anaplastic large cell lymphoma)

### STRONGLY RECOMMEND:
- Core biopsy for tissue banking by protocol

---

1 Review MD Anderson approved biomarkers
2 See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

Copyright 2022 The University of Texas MD Anderson Cancer Center

Department of Clinical Effectiveness V7

Approved by the Executive Committee of the Medical Staff on 06/21/2022
Hodgkin Lymphoma

Classic Hodgkin Lymphoma Stage I-II Combined Modality Therapy

Disclaimers: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

NOTE: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION

Favorable per GHSG?

Yes

ABVD for 2 cycles

No

ABVD for 2 cycles

PET/CT

ABVD for 2 cycles followed by PET/CT

Deauville/5PS

1-3

Deauville/5PS

4

Deauville/5PS

5

ABVD for 2 cycles

Biopsy

Biopsy

Biopsy negative?

Yes

No

Complete response

Yes

No

See Page 8: Follow-up After Completion of Treatment

TREATMENT

ISRT

Yes

Biopsy

No

Multidisciplinary conference with disease site specialist

Excisional biopsy if available

ABVD for 2 cycles with ISRT or AVD for 4 cycles with or without ISRT

See Page 8: Follow-up After Completion of Treatment

Complete response

Yes

ISRT

No

Biopsy

Multidisciplinary conference with disease site specialist

Excisional biopsy if available

See Page 9: Salvage Therapy

Follow-up After Completion of Treatment

ABVD = doxorubicin, bleomycin, vinblastine, dacarbazine
AVD = doxorubicin, vinblastine, dacarbazine
ISRT = involved site radiation therapy
GHSG = German Hodgkin Study Group

1 See Appendix A: Unfavorable Risk Factors for Stage I-II Classic Hodgkin Lymphoma
2 See Appendix B: Deauville Criteria/5-Point Scale (5PS)
3 See Appendix C: Radiation Therapy Guidelines
4 Consider multidisciplinary conference with disease site specialist

Copyright 2022 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 06/21/2022
### Hodgkin Lymphoma

**Classic Hodgkin Lymphoma Stage I-II Chemotherapy Alone**

**NOTE:** Consider Clinical Trials as treatment options for eligible patients.

<table>
<thead>
<tr>
<th><strong>CLINICAL PRESENTATION</strong></th>
<th><strong>PRIMARY TREATMENT</strong></th>
<th><strong>RESPONSE EVALUATION</strong></th>
<th><strong>TREATMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Classic Hodgkin Lymphoma</td>
<td>ABVD for 2 cycles</td>
<td>PET/CT</td>
<td>Biopsy negative?</td>
</tr>
<tr>
<td>Stage I-II</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Favorable/Unfavorable³</td>
<td></td>
<td></td>
<td>Multidisciplinary conference with disease site specialist</td>
</tr>
<tr>
<td>Non-bulky with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preference to treat with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chemotherapy alone²</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Deauville/5PS³

1-3

Deauville/5PS³

4

Deauville/5PS³

5

### RESPONSE EVALUATION

- ABVD for 1 to 2 cycles or AVD for 4 cycles
- For initial stage IIB or ≥ 3 nodal regions or ESR > 50: AVD for 4 cycles (total 6 cycles)

### TREATMENT

- See Page 8: Follow-up After Completion of Treatment
- Multidisciplinary conference with disease site specialist
- Excisional biopsy if available

**Biopsy negative?**

- Yes
- No: See Page 9: Salvage Therapy

**ABVD** = doxorubicin, bleomycin, vinblastine, dacarbazine

**AVD** = doxorubicin, vinblastine, dacarbazine

³ See Appendix B: Deauville Criteria/5-Point Scale (5PS)

---

1 See Appendix A: Unfavorable Risk Factors for Stage I-II Classic Hodgkin Lymphoma
2 A subset of patients who meet criteria as per the UK Rapid study with stage IA and stage IIA Hodgkin Lymphoma with no mediastinal bulk and negative PET findings after treatment may receive 3 cycles of chemotherapy with or without additional involved site radiation therapy (ISRT)
3 See Appendix B: Deauville Criteria/5-Point Scale (5PS)

**NOTE:** This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.
Hodgkin Lymphoma

Note: Consider Clinical Trials as treatment options for eligible patients.

Clinical Presentation

Primary Treatment

Initial Response Evaluation

Treatment

ABVD = doxorubicin, bleomycin, vinblastine, dacarbazine
AVD = doxorubicin, vinblastine, dacarbazine
BV = brentuximab vedotin
IPS = International Prognostic Score
ISRT = involved site radiation therapy

1 Advanced stage is consistent with an IPS ≥ 4, age < 60 years [see Appendix D: International Prognostic Score (Hasenclever Index)]

2 Choice of regimen is based on IPS, comorbidities and physician discretion

3 Patients with IPS ≥ 4 and age < 65 years may benefit from BV plus AVD. Patients with underlying neuropathy should proceed with caution. Patients who are at higher risk for bleomycin lung toxicity should be considered for BV plus AVD.

4 See Appendix B: Deauville Criteria/5-Point Scale (5PS)

5 See Appendix C: Radiation Therapy Guideline

Copyright 2022 The University of Texas MD Anderson Cancer Center

Department of Clinical Effectiveness V7
Approved by the Executive Committee of the Medical Staff on 06/21/2022
**CLINICAL PRESENTATION**

- **ABVD** = doxorubicin, bleomycin, vinblastine, dacarbazine
- **ISRT** = involved site radiation therapy

**NOTE:** Consider Clinical Trials as treatment options for eligible patients.

**RESPONSE EVALUATION**

- **PET Deauville/5PS²**
  - 1-3
  - 4-5

- **Biopsy**

**TREATMENT**

- ABVD for 2 cycles (total of 6 cycles) with consideration of ISRT³ to bulky sites

  - Yes
    - Multidisciplinary conference with disease site specialist
    - Excisional biopsy if available

  - No
    - See Page 9: Salvage Therapy

- See Page 8: Follow-up After Completion of Treatment

---

**Classic Hodgkin Lymphoma Advanced Stages III, IV¹**

- End of Therapy Response Evaluation and Treatment

---

**DISCLAIMER:** This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

**NOTE:**

- ABVD = doxorubicin, bleomycin, vinblastine, dacarbazine
- ISRT = involved site radiation therapy

1 Advanced stage is consistent with an International Prognostic Score \( \geq 4 \), age < 60 [see Appendix D: International Prognostic Score (Hasenclever Index)]

2 See Appendix B: Deauville Criteria/5-Point Scale (5PS)

3 See Appendix C: Radiation Therapy Guideline
Lymphocyte Predominant Hodgkin Lymphoma

CLINICAL PRESENTATION

- Lymphocyte Predominant Hodgkin Lymphoma Stages IA, IIA (non-bulky)
  - Observe or ISRT

- Lymphocyte Predominant Hodgkin Lymphoma Stage IIA (bulky)
  - Rituximab or ISRT
  - Consider R-CHOP for bulky, subdiaphragmatic, or splenic disease followed by involved site radiation therapy for patients with bulky disease

- Lymphocyte Predominant Hodgkin Lymphoma Stages IB, IIB
  - Rituximab and ISRT
  - Consider R-CHOP for bulky, subdiaphragmatic, or splenic disease followed by involved site radiation therapy for patients with bulky disease

- Lymphocyte Predominant Hodgkin Lymphoma Stages III, IV
  - Rituximab or R-CHOP for 3-6 cycles
  - Consider ISRT to bulky sites following R-CHOP

PRIMARY TREATMENT

INITIAL RESPONSE EVALUATION

- PET/CT negative?
  - Observe
  - Yes
  - No
  - Biopsy
  - Biopsy negative?
  - Yes
  - Multidisciplinary conference with disease site specialist
  - Excisional biopsy if available
  - No
  - See Page 9: Salvage Therapy

NOTE: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION PRIMARY TREATMENT INITIAL RESPONSE EVALUATION

ISRT = involved site radiation therapy
R-CHOP = rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone

1 See Appendix C: Radiation Therapy Guideline
FOLLOW-UP AFTER COMPLETION OF TREATMENT

- Follow-up with an oncologist is recommended
- Interim history and physical: every 4 months for years 1 and 2, then every 6 months for year 3, then annually
- Pneumococcal and meningococcal revaccination if patient treated with splenic radiation therapy. See Management of Adult Asplenic/Hyposplenic Patients algorithm.
- Annual influenza vaccine (especially if patient treated with bleomycin or chest radiation therapy)
- Laboratory studies:
  - CBC with differential, LDH, BUN, creatinine, albumin, AST, ALT, total bilirubin, alkaline phosphatase, serum calcium, uric acid every 4 months for years 1 and 2, then every 6 months for years 3, then annually
  - TSH every 6 months if radiation therapy to neck and optional for all other cases
- CT neck, chest, abdomen and pelvis with contrast at 6, 12, and 24 months or as clinically indicated. PET/CT only if last PET was Deauville/5PS 4-5, to confirm complete response
- Annual breast screening: If radiation therapy to the chest or axilla, initiate breast screening 8 years post therapy or at age 40 years, whichever is sooner. If radiation therapy was given between the ages of 10 and 30 years, breast MRI should be performed in addition to mammography.
- Counseling: reproduction, health habits, psychosocial, cardiovascular, breast self-exam, skin cancer risk, end-of-treatment discussion
- Recommend written follow-up instructions for the patient
- Stress test/echocardiogram at 10-year intervals after treatment is completed
- Consider carotid ultrasound at 10-year intervals if neck irradiation

NOTE: Consider Clinical Trials as treatment options for eligible patients.
Hodgkin Lymphoma

NOTE: Consider Clinical Trials as treatment options for eligible patients.

**SALVAGE THERAPY**

- **Relapse or Refractory disease**
  - Systemic therapy for relapse or refractory disease (see Appendix E) followed by PET/CT
    - Complete response
      - **AH SCT** with or without locoregional radiation therapy
      - **Consider maintenance therapy with BV or pembrolizumab** for patients with primary refractory disease or any of the following risk factors:
        - Early relapse < 12 months
        - Extranodal disease at time of relapse
        - Not in CR at time of AH SCT
        - B symptoms
        - Greater than 1 salvage/subsequent therapy regimen

- **Partial response**
  - Consider changing to different regimen

- **AH SCT** = autologous hematopoietic stem cell transplant
- **BV** = brentuximab vedotin
- **CAR** = chimeric antigen receptor

**RESPONSE EVALUATION**

- **AH SCT** with or without locoregional radiation therapy
- **Considering maintenance therapy with BV or pembrolizumab** for patients with primary refractory disease or any of the following risk factors:
  - Early relapse < 12 months
  - Extranodal disease at time of relapse
  - Not in CR at time of AH SCT
  - B symptoms
  - Greater than 1 salvage/subsequent therapy regimen

- **Progressive disease post AH SCT?**
  - **Yes**
    - **Consider gemcitabine-based chemotherapy or immunotherapy or other cellular therapies if not previously given**
    - **Clinical trial**
  - **No**
    - **Consider**
      - **AH SCT** or locoregional radiation therapy
      - **Consider**
        - Maintenance therapy with BV or pembrolizumab
        - **Clinical trial** or **CAR T-cell therapy trial**
      - **Consider**
        - **Clinical trial** or **Allogenic stem cell transplant**
      - **Clinical or CAR T-cell therapy trial** or **Consider clinical trial**

---

2 Conventional-dose chemotherapy may precede high-dose therapy. Sequence of therapy may vary.
3 Perform biopsy if plan to treat with high-dose chemotherapy
4 Extranodal disease (i.e., any tumor spread that involves tissues other than those of the lymph nodes, spleen, thymus, Waldeyer’s tonsillar ring, appendix, and Peyer’s patches)
5 Unexplained fever > 38°C during the previous month, recurrent drenching night sweats during the previous month, weight loss > 10% of body weight ≤ 6 months of diagnosis
6 See Appendix E: Systemic Therapy for Relapse or Refractory Disease

**NOTE:** This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

**Disclaimer:**
This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

Copyright 2022 The University of Texas MD Anderson Cancer Center

Approved by the Executive Committee of the Medical Staff on 06/21/2022
### APPENDIX A: Unfavorable Risk Factors for Stage I-II Classic Hodgkin Lymphoma

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>GHSG</th>
<th>EORTC</th>
<th>NCCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>≥ 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESR and B symptoms&lt;sup&gt;1&lt;/sup&gt;</td>
<td>ESR &gt; 50 mm/hour if A; ESR &gt; 30 mm/hour if B</td>
<td>ESR &gt; 50 mm/hour if A; ESR &gt; 30 mm/hour if B</td>
<td>ESR ≥ 50 mm/hour or any B symptoms&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mediastinal mass</td>
<td>MMR &gt; 0.33</td>
<td>MTR &gt; 0.35</td>
<td>MMR &gt; 0.33</td>
</tr>
<tr>
<td># Nodal sites</td>
<td>Area ≥ 3&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Sites &gt; 3&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Sites &gt; 3</td>
</tr>
<tr>
<td>E lesion</td>
<td>any</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulky&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td>Size &gt; 10 cm</td>
<td></td>
</tr>
</tbody>
</table>

A = no B symptoms
GHSG = German Hodgkin Study Group
EORTC = European Organization for the Research and Treatment of Cancer
MMR = Mediastinal mass ratio, maximum width of mass/maximum intrathoracic diameter
MTR = Mediastinal thoracic ratio, maximum width of mediastinal mass/intrathoracic diameter at T5-6
NCCN = National Comprehensive Cancer Network

<sup>1</sup> Unexplained fever > 38°C during the previous month, recurrent drenching night sweats during the previous month, weight loss > 10% of body weight ≤ 6 months of diagnosis

<sup>2</sup> The EORTC includes the infraclavicular/subpectoral area with the axilla area while the GHSG includes this area with the cervical. Both EORTC and GHSG combine the mediastinum and bilateral hila as a single region.

<sup>3</sup> Bulky may be defined as MMR > 0.33 or any mass >10 cm in size

### APPENDIX B: Deauville Criteria/5-Point Scale (5PS)

- Score 1: no uptake
- Score 2: uptake less than or equal to mediastinum
- Score 3: uptake greater than mediastinum but less than or equal to liver
- Score 4: uptake moderately greater than liver
- Score 5: uptake markedly greater than liver and/or new sites of disease
- Score X: new areas of uptake unlikely to be related to lymphoma

A Deauville Criteria/5PS score of 1-3 is regarded as negative and 4 or 5 as positive
APPENDIX C: Radiation Therapy Guidelines

Consider intensity-modulated radiation therapy (IMRT) or proton therapy, as appropriate, to minimize toxicity

Dose if radiation therapy is given alone:
30-45 Gy, depending on treatment intent, disease bulk, etc.

Doses for combined modality radiation therapy:
● Early stage favorable: 20 Gy to involved site
● Early stage unfavorable: 30 Gy to involved site

Salvage radiation therapy when Deauville/5PS ≥ 4:\n36-45 Gy, depending on disease bulk and response to chemotherapy

Radiation Fields:
Involved Site Radiation Therapy: Treatment of involved lymph nodes regions only

1 See Appendix B: Deauville Criteria/5-Point Scale (5PS)
Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

APPENDIX D: International Prognostic Score (Hasenclever Index)

- Albumin < 4 g/dL
- Hemoglobin < 10.5 g/dL
- Male
- Age ≥ 45 years
- Stage IV disease
- White blood cell count ≥ 15 K/microliter
- Lymphocyte count < 8% of white blood cell count, and/or lymphocyte count < 0.6 K/microliter

Each factor = 1 point

APPENDIX E: Systemic Therapy for Relapsed or Refractory Disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>Chemotherapy Options</th>
<th>Subsequent Options[^1]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classic Hodgkin Lymphoma</strong></td>
<td>• Brentuximab vedotin</td>
<td>• Bendamustine</td>
</tr>
<tr>
<td></td>
<td>• Brentuximab vedotin plus bendamustine</td>
<td>• Everolimus</td>
</tr>
<tr>
<td></td>
<td>• Brentuximab vedotin plus nivolumab</td>
<td>• GCD (gemcitabine, carboplatin, dexamethasone)</td>
</tr>
<tr>
<td></td>
<td>• DHAP (dexamethasone, cisplatin, high dose cytarabine)</td>
<td>• Lenalidomide</td>
</tr>
<tr>
<td></td>
<td>• ESHAP (etoposide, methylprednisolone, high dose cytarabine, cisplatin)</td>
<td>• MINE (etoposide, ifosfamide, mesna, mitoxantrone)</td>
</tr>
<tr>
<td></td>
<td>• Gemcitabine/bendamustine/vinorelbine</td>
<td>• Mini-BEAM (carmustine, cytarabine, etoposide, melphalan)</td>
</tr>
<tr>
<td></td>
<td>• GVD (gemcitabine, vinorelbine, liposomal doxorubicin)</td>
<td>• Nivolumab</td>
</tr>
<tr>
<td></td>
<td>• ICE (ifosfamide, carboplatin, etoposide)</td>
<td>• Pembrolizumab</td>
</tr>
<tr>
<td></td>
<td>• IGEV (ifosfamide, gemcitabine, vinorelbine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pembrolizumab plus GVD (gemcitabine, vinorelbine, liposomal doxorubicin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pembrolizumab for patients not eligible for stem cell transplant</td>
<td></td>
</tr>
<tr>
<td><strong>Lymphocyte Predominant Hodgkin Lymphoma</strong></td>
<td>• Rituximab plus DHAP (dexamethasone, cisplatin, high dose cytarabine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rituximab plus ESHAP (etoposide, methylprednisolone, high dose cytarabine, cisplatin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rituximab plus ICE (ifosfamide, carboplatin, etoposide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rituximab plus IGEV (ifosfamide, gemcitabine, vinorelbine)</td>
<td></td>
</tr>
</tbody>
</table>

[^1] Subsequent options also include chemotherapy options that were not previously given.
Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS


Continued on next page

Approved by the Executive Committee of the Medical Staff on 06/21/2022
Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS - continued


Continued on next page
Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS - continued


Hodgkin Lymphoma

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

DEVELOPMENT CREDITS

This practice algorithm is based on majority expert opinion of the Lymphoma Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Core Development Team Lead
Sairah Ahmed, MD (Lymphoma/Myeloma)
Jillian R. Gunther, MD, PhD (Radiation Oncology)

Workgroup Members
Bouthaina S. Dabaja, MD (Radiation Oncology)
Olga N. Fleckenstein, BS*
Hun Ju Lee, MD (Lymphoma/Myeloma)
L. Jeffrey Medeiros, MD (Hematopathology Administration)
Loretta Nastoupil, MD (Lymphoma/Myeloma)
Chelsea Pinnix, MD, PhD (Radiation Oncology)
Brian Primeaux, PharmD (Clinical Pharmacy Programs)
Felipe Samaniego, MD (Lymphoma/Myeloma)
Raphael E. Steiner, MD (Lymphoma/Myeloma)
Paolo Strati, MD (Lymphoma/Myeloma)
Mary Lou Warren, DNP, APRN, CNS-CC*
Terri L. Woodard, MD (Gynecological Oncology & Reproductive Medicine)

*Clinical Effectiveness Development Team